PATIENT INFORMATION

Patient's Name____

Last First Middle

Address ______________________________City ________________State ________ Zip__________

HomeÁ[¦ÁÔ^||ÁPhone ________________´´´´´´´´ÁSS# __________________ Birth Date ____________Age ____

Employed by ___________________________Employer's phone______________ Work Related ? Y N

Work Address __________________________City___________________ State________ Zip ________

Email address___________________________________

Sex: M F Marital Status: Single Married Divorced Widowed Separated

Name of Spouse or if a minor, Parent's name: ____

How did you hear about us? Word of mouth Yellow Pages Dr______________________

Name of relative not living with you ___________________________________ Phone # ______________

Address ______________________________City_____________ State__________ Zip__________

INSURANCE INFORMATION

PRIMARY INSURANCE:

Do you have a Vision Plan that is separate from your Medical Plan? Yes No

Main Person Insured: _____________________________________ Insured's date of birth______________

Insurance Company______________________________Employer of Insured _______________________

Policy/Group ID # _____________ Subscriber ID #___________________SS # ____________________

Relationship to patient: Self Spouse Son Daughter Mother Father Other______________

SECONDARY INSURANCE:

Is this a Davis Vision Plan? Yes No Eye Med Plan? Yes No

Person Insured: ______________________________________ Insured's date of birth ______________

Insurance Company ___________________________Employer of Insured __________________________

Policy/Group ID #______________ Subscriber ID #___________________SS #_____________________

Relationship to patient: Self Spouse Son Daughter Mother Father Other ______________

FINANCIAL POLICY

I authorize the release of any information required in the course of my examination or treatment by the physician.
I authorize payment of medical benefits to the undersigned physician for services described.
I give the physician permission to treat this minor child in my absence.

Agreement for Extension of Credit:

In accordance with the Federal Truthin-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply in this office. The responsible party agrees to: **(Must be 18 years or older to provide signature.)**

1. **Pay the doctor at the time treatment or service is received or by previous arrangements.**
2. Pay for all legal fees and costs incurred in connection with debt collection with or without suit.
3. Pay the balance in full if my insurance company does not cover the entire balance of this account.
4. Pay a late fee of $5.00 per month after 90 days from the date of service.
5. Return checks will be subject to a $20.00 return check fee.
6. **Call 24 hours in advance to cancel or change an appointment to avoid a $100 fee.**
7. It is your responsibility to provide current and accurate insurance information. Failure to do so will cause your visit to be self pay until insurance billing information is received.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for services rendered. I have read all information on this form and consent to the terms outlined. I certify that all information provided on this form is true to the best of my knowledge. I understand these policies are subject to change without notice.

Responsible Party Signature ______________________________ **Date:** ______________

(Must be over 18 years of age) Relationship to patient: Father Mother Guardian Other ________________